Gregory G Lai & Associates

Mr G Lai & Associates - Harlesden

Inspection report

83 High Street
Harlesden
London
NW10 4NT
Tel: 02089654700

Date of inspection visit: 13 April 2022
Date of publication: 12/05/2022

Overall summary

We carried out this announced focused inspection on 13 April 2022 under section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. We planned the inspection to check whether the registered practice was meeting the legal requirements in the Health and Social Care Act 2008 and associated regulations. The inspection was led by a Care Quality Commission (CQC) inspector who was supported by a specialist dental adviser.

To get to the heart of patients' experiences of care and treatment, we usually ask five key questions, however due to the ongoing pandemic and to reduce time spent on site, only the following three questions were asked:

• Is it safe?

• Is it effective?

• Is it well-led?

These questions form the framework for the areas we look at during the inspection.

Our findings were:

- The dental clinic appeared to be visibly clean.
- Safeguarding processes were in place and staff knew their responsibilities for safeguarding vulnerable adults and children.
- The practice had staff recruitment procedures which reflected current legislation.
- Staff provided preventive care and supported patients to ensure better oral health.
- Staff felt involved and supported and worked as a team.
- The dental clinic had information governance arrangements.

Summary of findings

- The practice had infection control procedures which broadly reflected published guidance. However, improvements were needed to ensure the effectiveness of the decontamination process.
- Staff knew how to deal with medical emergencies. However, not all emergency equipment and medicines were available as described in the Resuscitation Council UK 2021 guidelines.
- Risks to staff and patients from undertaking of regulated activities had not been suitably identified and mitigated.
- The clinical staff provided patients' care and treatment in line with current guidelines, however improvements were needed to ensure that information related to patient care was suitably recorded within the dental care records.
- There was ineffective leadership and a lack of management oversight for the day-to-day management of the service.
- There were ineffective systems to ensure facilities were safe and equipment was serviced and maintained according to manufacturers` guidance.

Background

The provider Mr G Lai & Associates has three practices and this report is about Mr G Lai & Associates- Harlesden.

Mr G Lai & Associates - Harlesden is in Harlesden, in the London Borough of Brent, and provides NHS dental care and treatment for adults and children.

The dental practice is on the ground floor of a high street building with narrow corridors, so it is not accessible to wheelchair users. The service signposts people with mobility needs to nearby practices.

Metered parking spaces are available near the practice and it is also located close to public transport services.

The dental team includes one principal dentist, two dental associates, one qualified dental nurse, one trainee dental nurse and one practice manager. The practice has two treatment rooms.

During the inspection we spoke with one dentist, one qualified dental nurse, one trainee dental nurse, the practice manager and the registered manager. We looked at practice policies and procedures and other records about how the service is managed.

The practice is open:

Monday to Friday from 9.30am to 6pm.

Saturday 9.30am to 2pm.

We identified regulations the provider was not complying with. They must:

- Ensure care and treatment is provided in a safe way to patients.
- Establish effective systems and processes to ensure good governance in accordance with the fundamental standards of care.

Full details of the regulations the provider was not meeting are at the end of this report.

There were areas where the provider could make improvements. They should:

Summary of findings

Take action to ensure that clinicians carry out patient assessments and treatments in compliance with current legislation and take into account relevant nationally recognised evidence-based guidance.

Summary of findings

The five questions we ask about services and what we found

We asked the following question(s).

Are services safe?	**Enforcement action** 
Are services effective?	**No action** 
Are services well-led?	**Enforcement action** 

Are services safe?

Our findings

We found this practice was not providing safe care in accordance with the relevant regulations. We have told the provider to take action (see full details of this action in the Enforcement Actions section at the end of this report). We will be following up on our concerns to ensure they have been put right by the provider.

Safety systems and processes, including staff recruitment, equipment and premises and radiography (X-rays)

The practice had safeguarding processes and staff knew their responsibilities for safeguarding vulnerable adults and children.

The practice had infection control procedures which broadly reflected published guidance. The practice had introduced additional procedures in relation to COVID-19 in accordance with published guidance. However, we found shortcomings in the effectiveness of the infection prevention and control procedures at the practice.

We observed that some instruments appeared to have rust and glass ionomer cement residue. Some instruments were not stored according to the guidelines and were kept in an open pouch following sterilisation. We noted that local anaesthetics ampoules were not stored in the blister packs.

We saw the practice had some procedures to reduce the possibility of legionella or other bacteria developing in the water. There were protocols in place for flushing and disinfecting the dental unit water lines (DUWLs) as set out in The Health Technical Memorandum 01-05: Decontamination in primary dental practices (HTM01-05), published by the Department of Health and Social Care. However, on the day of inspection a legionella risk assessment was not available, and the practice was unaware if any actions were required in order to appropriately maintain water systems in the practice. The registered manager told us that the legionella risk assessment had been completed a week before the inspection and they were awaiting the report.

We observed that the rubber dam expired in 2001 and rubber dam clamps were not sterilised and pouched separately. The provider told us that they did not undertake root canal treatments and the rubber dam and rubber dam claps are not in use.

The practice had policies and procedures in place to ensure clinical waste was segregated and stored appropriately in line with guidance. However, improvements were required to ensure that documentation relating to waste management arrangements were stored and managed effectively and information about waste collection arrangements were clearly communicated to staff.

We saw the practice was visibly clean and there was an effective cleaning schedule to ensure the practice was kept clean.

The practice had a recruitment policy and procedure to help them employ suitable staff and had checks in place for agency and locum staff. These reflected the relevant legislation.

Clinical staff were qualified, registered with the General Dental Council and had professional indemnity cover.

The practice had not ensured all facilities and equipment were safe, and that equipment was maintained according to manufacturers` instructions. We noted the 5-year fixed wiring electrical testing had not been undertaken. In addition, there was no evidence the suction motor, the compressor and the dental chairs had been serviced. The provider could not demonstrate that all portable appliances had been safety checked. The registered manager told us that portable appliance testing (PAT) had been completed a week before the inspection and they were awaiting the relevant certificates.

Are services safe?

The dental chair bracket table in Surgery 2 was broken and it was supported by a dental chair. Surgery 2 was still in use for consultations and minor denture adjustments and no risk assessment had been carried out to identify any risks associated with treating patients on a faulty dental chair.

The risks around fire safety had not been assessed and the management of fire safety was ineffective.

The provider did not have records to indicate that smoke detectors, the emergency lighting system and the fire alarm system were tested and serviced regularly. The fire extinguisher was last serviced in 2004 and was deemed non-conformant. We observed that the rear fire exit door led to a locked gate, blocking one of the two fire escape routes. The fire evacuation plan was not displayed and there was no evidence that fire-drills were being carried out.

The practice did not have arrangements to ensure the safety of the X-ray equipment. The required radiation protection information was not available and there was no evidence regular in-house quality assurance tests and periodic calibration and dosage tests of the X-ray equipment were carried out in line with the guidelines. Rectangular collimators were not available.

The practice could not demonstrate that they had registered the use of radiographic equipment with the Health and Safety Executive (HSE).

Clinicians did not grade radiographs appropriately and a radiography audit was not available for review.

Risks to patients

Systems and processes to assess, monitor and manage risks to patients and staff were ineffective.

A sharps risk assessment had been completed but it was not tailored to the service and did not accurately reflect the sharps safety arrangements within the service. We found that the sharps container in one of the treatment rooms was not locked correctly, increasing the risk of needlestick injury.

The needlestick injury poster did not include the Occupational Health or the nearest Accident & Emergency department contact details.

Emergency equipment and medicines were not available as described in the Resuscitation Council UK 2021 guidelines. Buccal Midazolam (an emergency medicine to treat epileptic seizures) was not available. Glucagon (an emergency medicine used to treat severe low blood sugar) was stored in the fridge but a thermometer was not available, and the fridge temperature was not monitored.

Staff knew how to respond to medical emergencies and had completed training in emergency resuscitation and basic life support every year.

On the day of the inspection, the provider had some information available in relation to the use and storage of hazardous substances as per Control of Substances Hazardous to health regulations 2002 (COSHH). However, improvements were needed to ensure that safety data information and risk assessment is available for all hazardous materials used in the practice. Improvements were also needed to ensure that information was organised and easily accessible and staff new what to do in case of an incident while using hazardous materials. In addition, we noted that the COSHH cabinet was not lockable.

Information to deliver safe care and treatment

Dental care records were kept securely and complied with General Data Protection Regulation requirements. However, improvements were needed to ensure that dental care records are complete and legible.

The practice had systems for referring patients with suspected oral cancer under the national two-week wait arrangements.

Are services safe?

Safe and appropriate use of medicines

The practice had systems for appropriate and safe handling of medicines. Antimicrobial prescribing audits were carried out.

Track record on safety, and lessons learned and improvements

The practice had implemented systems for reviewing and investigating incidents and accidents. The practice had a system for receiving and acting on safety alerts.

Are services effective?

(for example, treatment is effective)

Our findings

We found this practice was providing effective care in accordance with the relevant regulations.

Effective needs assessment, care and treatment

The practice had systems to keep dental professionals up to date with current evidence-based practice. However, improvements were needed to ensure that all clinicians had awareness of the relevant guidelines, including those relating to antibiotic prophylaxis for endocarditis patients and the restrictions on the use of dental amalgam in deciduous teeth of children under 15 years.

Helping patients to live healthier lives

The practice provided preventive care and supported patients to ensure better oral health.

Consent to care and treatment

Staff obtained patients' consent to care and treatment in line with legislation and guidance. The dentist told us that they gave patients information about treatment options and the benefits of these, so they can make informed decisions. Improvements were needed to ensure that this information was consistently recorded within the dental care records.

Staff understood their responsibilities under the Mental Capacity Act 2005.

Staff described how they involved patients' relatives or carers when appropriate and made sure they had enough time to explain treatment options clearly.

Monitoring care and treatment

Most dental care records in the practice were paper based. Improvements were needed to ensure that information, including diagnosis and Basic Periodontal Examination (BPE) were consistently recorded in line with the College of General Dentistry (CGDent) guidelines. Improvements were also needed to ensure that dental charts were appropriately updated to reflect the treatment carried out. The registered manager told us that they are looking to implement a digital clinical software for more effective record keeping.

We saw evidence the dentists justified and reported on the radiographs they took. However, improvements were needed to ensure that six-monthly radiography audits were carried out following the current guidance and legislation and the new system was used to grade radiographs.

Effective staffing

Staff had the skills, knowledge and experience to carry out their roles.

Newly appointed staff had a structured induction and clinical staff completed continuing professional development required for their registration with the General Dental Council.

Co-ordinating care and treatment

Staff worked together and with other health and social care professionals to deliver effective care and treatment.

The dentists confirmed they referred patients to a range of specialists in primary and secondary care for treatment the practice did not provide.

Are services well-led?

Our findings

We found this practice was not providing well-led care in accordance with the relevant regulations. We have told the provider to take action (see full details of this action in the Enforcement Actions section at the end of this report). We will be following up on our concerns to ensure they have been put right by the provider.

Leadership capacity and capability

We found that there was ineffective and inconsistent leadership which impacted on the practice`s ability to deliver safe, high quality care. The registered manager could not assure us that they understood risks pertaining to the management of the service and the delivery of care.

Systems and processes to ensure continuous improvement were ineffective. Risk assessments, including the internal fire, general health and safety and sharps risk assessments were generic, not tailored to the service and did not reflect the arrangements within the practice.

We found that staff members worked well together and were supportive of each other. However, improvements were needed to ensure important information about systems and processes was communicated effectively across the organisation.

The information and evidence presented during the inspection process was not always well documented. Improvement were needed to ensure that records in relation to the management of regulated activities are readily available and easily accessible to all members of staff and those who would need to review them.

Culture

Staff stated they felt respected, supported and valued. They enjoyed working at the practice.

The practice had arrangements to ensure staff training was up-to-date and reviewed at the required intervals.

Governance and management

The registered manager had overall responsibility for the management of the practice. Improvements were needed to ensure that they were more involved in the day to day running of the service or to ensure that effective deputising arrangements were in place in their absence.

There was a lack of clear roles and systems for accountability to support good governance and management.

The practice did not have effective systems and processes in place in relation to the management of the service. We noted that several essential requirements, including servicing of equipment had not been undertaken regularly in the past and some were only booked in response to the CQC inspection being announced. For example, the practice did not have a radiation protection advisor (RPA) and one was appointed only in April 2022. Legionella risk assessment was completed the week before the inspection and the fire risk assessment and compressor servicing was scheduled for the week following our inspection.

The processes for managing risks were ineffective. The practice did not have adequate systems in place for identifying, assessing and mitigating risks in areas such as sharps, fire safety, legionella and general health and safety. Some risks assessments were generic and not reflective of the arrangements within the service and others were not available at all.

Appropriate and accurate information

We found that staff were not always able to act on accurate and appropriate information. For example, the lockable clinical waste bin had been removed by the contractor on 24 March 2022 but until the day of the inspection, only one member of staff had been aware of this change.

Are services well-led?

The practice had information governance arrangements and staff were aware of the importance of these in protecting patients' personal information.

Engagement with patients, the public, staff and external partners

Staff gathered feedback from patients, the public and external partners and a demonstrated commitment to acting on feedback.

The practice gathered feedback from staff through meetings, surveys, and informal discussions. Staff were encouraged to offer suggestions for improvements to the service and said these were listened to and acted on.

Continuous improvement and innovation

The practice did not have effective systems and processes for learning, continuous improvement and innovation. Records were not available to demonstrate audits of radiographs were undertaken and re-assessed at the required intervals. The infection prevention audit was not completed accurately, and the findings did not reflect the arrangements within the practice. There was no evidence that annual staff appraisals had been carried out to identify individual training and development needs.

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

The table below shows the legal requirements that were not being met.

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment The registered person had not done all that was reasonably practicable to mitigate risks to the health and safety of service users receiving care and treatment. In particular: • There was no evidence that a fire risk assessment considered all risks associated with fire and had been carried out by a person with the qualifications, skills and experience to do. • The rear fire exit door led to a locked gate, blocking one of the two fire evacuation routes. • There was no evidence that fire drills had been carried out to demonstrate any issues or areas for improvement. • There were no records of periodic in-house testing of the fire safety equipment, including the fire alarm system and emergency lighting, and we saw no evidence of the servicing of these. • The fire extinguisher was last serviced in 2004 and was deemed non-conformant. • There was no evidence that equipment had been serviced and maintained according to manufacturers' guidance. There were no records to demonstrate that the compressor, dental suction and dental chairs had been serviced. • One of the dental bracket tables was broken and the dental chair was still in use for consultations and minor procedures. • Important safety assessments had not been carried out. The electrical 5-year fixed wire safety certificate and records of portable appliance tests were not available. • The medicines to treat medical emergencies were not available as per relevant national guidance. • The decontamination of used dental instruments was not carried out in accordance with HTM 01-05.

This section is primarily information for the provider

Enforcement actions

- COSHH assessments had not been carried out for all material used in the practice.
- The COSHH cabinet was not locked.
- There were no arrangements to ensure the safety of the X-ray equipment. The required radiation protection information was not available and there was no evidence that quality assurance tests were carried out in line with the regulations.
- There was no evidence that X-Ray equipment validation, such as critical examination tests and three-yearly service, including calibration and dosage tests had been carried out.
- There was no evidence that the provider had registered the use of X-ray equipment with the Health and Safety Executive.
- The sharps container was not locked properly.

Regulation 12 (1)

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance Systems or processes must be established and operated effectively to ensure compliance with the requirements of the fundamental standards as set out in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. In particular: The registered person had systems or processes in place that operated ineffectively in that they failed to enable the registered person to assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk. In particular: • A legionella risk assessment was not available, to identify if any actions were required in order to appropriately maintain water systems in the practice • Risk assessments were ineffective and not reflective of the arrangements within the service • The needlestick injury poster did not include the Occupational Health or local A&E contact details.

This section is primarily information for the provider

Enforcement actions

- Not all clinical waste management records were readily available and there was inconsistent information about waste collection frequency.

There were no systems or processes that enabled the registered person to assess, monitor and improve the quality and safety of the services being provided. In particular:

- Radiography audit was not available.
- The infection control audit completed on 1 December 2021 did not accurately reflect the infection prevention and control practices within the surgery.
- Governance systems were ineffective as they did not include sufficient oversight, scrutiny and overall responsibility by the registered manager.

The registered person had systems or processes in place that operated ineffectively in that they failed to enable the registered person to ensure that accurate, complete and contemporaneous records were being maintained securely in respect of each service user. In particular:

- Dental care records were illegible, and they did not accurately reflect assessments carried out and treatments provided to patients.

Regulation 17 (1)